

and histologies were recorded. Data was recorded on an excel sheet and analysed using SPSS version 15.

**Results** A total of 36 patients were included in the study. The median age was 42 years. Eleven percent ( $n = 4$ ) were referred from general medicine, 22% ( $n = 8$ ) from general surgery and 67% ( $n = 24$ ) from Gastroenterology for endoscopic investigations. Median HB level was 10g/dL. There were 4 patients on NSAIDs prior to referral.

Gastroscopy was performed in all patients and was normal in 94% ( $n = 34$ ). The remaining 6% ( $n = 2$ ) were diagnosed with *h pylori* gastritis ( $n = 1$ ), and benign pyloric stenosis ( $n = 1$ ). Duodenal (D2) biopsies were performed in 32 patients (89%), of which 1 patient was diagnosed with coeliac disease on histology. Three of the 4 patients with no D2 biopsies had a normal coeliac blood screen. Lower GI endoscopy (colonoscopy  $n = 30$ , flexible sigmoidoscopy  $n = 3$ ) was performed in 33 (92%), of which 85% ( $n = 28/33$ ) were macroscopically normal. Five patients had pathology encountered at endoscopy, these included adenomas ( $n = 3$ ), ulcerative colitis ( $n = 1$ ) and caecal carcinoma ( $n = 1$ ).

Patients with IDA and no GI symptoms ( $n = 21$ ); endoscopic diagnostic yield was 5% ( $n = 1$ ) for gastroscopy and 11% ( $n = 2/19$ ) for colonoscopy. The diagnostic yield in symptomatic patients was 7% ( $n = 1$ ) for gastroscopy and 21% ( $n = 3/14$ ) for colonoscopy.

There were 11 patients with IDA and an HB level over 11g/dL. All patients underwent gastroscopy with D2 biopsies and 10 patients underwent colonoscopy. All endoscopic investigations including D2 biopsies were normal.

**Conclusion** IDA in young males should always be investigated with bi-directional endoscopy, irrespective of symptoms. Although a small cohort, our study shows that the diagnostic yield is higher amongst patients with IDA and GI symptoms as well as IDA with an HB level below 11g/dL.

**Disclosure of Interest** None Declared.

#### PTH-043 DIFFICULT BILIARY ACCESS: EARLY EXPERIENCE WITH THE NEW DOUBLE WIRE TECHNIQUE COMPARED TO CONVENTIONAL PRECUT AT ERCP

doi:10.1136/gutjnl-2013-304907.530

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**Introduction** Selective cannulation of the common bile duct (CBD) during endoscopic retrograde cholangiopancreatography (ERCP) can be technically challenging. The precut technique is a tried and tested method of gaining biliary access when standard cannulation with either contrast or guidewire has failed. However, it does have a recognised higher risk of causing pancreatitis and when used it is currently advised to place a prophylactic pancreatic stent. A new technique, termed double guidewire, involves leaving a wire in the pancreatic duct to provide a "roadmap" for subsequent biliary wire cannulation.

**Objectives** To report our initial experience for the success and complication rate of the double guidewire technique.

**Methods** Retrospective analysis of all patients who underwent ERCP between April 2010 to April 2012 at our institution. Observed differences were tested with the Fisher's exact test.

**Results** 484 ERCP procedures, all having initial cannulation with either a single guidewire or contrast. Overall successful biliary cannulation for first ever ERCP was achieved in 95%. Attempted CBD cannulation was facilitated by double guidewire in 20 patients and precut in 19 patients. CBD cannulation was successful in 19/20 (95%) double guidewire patients and 15/19 (79%) precut patients ( $p = \text{NS}$ ).

Post-ERCP pancreatitis occurred in all procedures were 11/484 (2.2%), double guidewire 3/20 (15%) ( $p < 0.02$ ), precut 1/19 (5.3%). Prophylactic pancreatic stents were placed in 2 double guidewire patients and no precut patients. In the double guidewire group, patients with pancreatitis stayed longer (mean 8 days) in the hospital when compared to precut group (mean 3 days).

**Conclusion** Deep CBD cannulation could be equally achieved with the help of either the double guidewire or the precut technique. There was a significant increased risk of pancreatitis with the double guidewire technique presumably related to inadvertent and repeated wire cannulations of the pancreatic duct. We find that the double guidewire technique is technically easy and currently use it if pancreatic duct cannulation occurs on  $> 3$  occasions. However, when used we now also place a prophylactic pancreatic stent at the end of the procedure.

**Conflicts of interest** none

**Disclosure of Interest** None Declared.

#### PTH-044 THE SAFETY OF ERCP IN PATIENTS AGED 90 AND ABOVE

doi:10.1136/gutjnl-2013-304907.531

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**Introduction** The ageing population in the UK means that biliary diseases are becoming more common. Endoscopic Retrograde Cholangiopancreatography (ERCP) is therefore increasingly being used as a therapeutic strategy. However, the elderly population often have associated co-morbidities and poorer physical health, which would suggest that ERCP may be technically more challenging, or of higher risk in this group. We look at the safety of ERCP in patients over 90.

**Methods** Patients aged 90 or above who underwent ERCP from October 1999 to October 2012 were studied retrospectively. The data was extracted from a single centre computer ERCP database.

**Results** ERCPs performed in patients aged 90 or above represented 6.5% of a total of 4017 procedures. The age range of patients was from 90 to 103 years. Therapeutic intervention was required in 246/262 procedures (93.9%). 16 specific types of intervention were performed, with the majority being sphincterotomy (62.2%) or stent insertion (16.7%). The procedure related mortality was 0.76% (2/262). 1 death occurred following a significant bleed post sphincterotomy, the other death resulted from a retroperitoneal perforation following duodenal dilatation. Complications occurred in 5.3% (14/262) of procedures. The most frequently occurring complications were bleeding and cholangitis, each of which occurred in 3/262 (1.1%) patients. Perforation occurred in 2/262 patients (0.76%). Pancreatitis did not occur in any of the patients. There were no complications related to co-morbidity.

**Conclusion** The number of ERCPs being performed in elderly patients is likely to increase. The procedure related mortality and morbidity is comparable with national figures. ERCP in this group is safe, practical and has a definite therapeutic benefit in a large proportion of patients.

**Disclosure of Interest** None Declared.

#### PTH-045 ENDOSCOPIC SUBMUCOSAL DISSECTION FOR EARLY GASTRIC NEOPLASIA: PROSPECTIVE OUTCOMES FROM A SINGLE TERTIARY CENTRE

doi:10.1136/gutjnl-2013-304907.532

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**Introduction** Gastric cancer is the 4th leading cause of cancer death worldwide. Prognosis remains poor, largely due to late diagnosis. Early gastric neoplasia carries a far better prognosis with a 5 year survival of 85%. Traditionally, gastrectomy is the definitive locoregional treatment, but carries significant perioperative morbidity. For early gastric cancer without risk of nodal metastasis, endoscopic en bloc resection with endoscopic submucosal dissection (ESD) is a feasible alternative. We present a prospective cohort analysis of patients with early gastric neoplasia undergoing ESD at a single tertiary Centre in the United Kingdom

**Methods** Patients were all referred through local cancer networks after staging to exclude metastatic disease. Patients underwent gastroscopy with biopsy for histology and contrast computed tomography (CT) for staging. High definition endoscopy & chromoendoscopy with indigo carmine were used to help delineate lesions. Pathology was confirmed by expert GI pathologists prior to resection. Surgery was discussed with all patients as an alternative to ESD. All gastric ESD were performed under propofol sedation by a single endoscopist with specialist training.

**Results** Over 24 months, 19 patients underwent ESD. Mean age was 71 years (range 23–87). 68% were male. Two lesions (10%) were in the proximal stomach, 1 in mid body (5%) 16 in distal stomach (85%). Mean resection size was 28mm (15–58). Mean resection time was 71 mins from intubation. En-bloc resection was achieved in 15/19 (74%) patients. 16/19 patients (84%) had a clear deep resection margin. Resection histology was high grade dysplasia in 52%, carcinoma in situ 11%, LGD 5%, poorly differentiated adenocarcinoma 21%, neuroendocrine tumour in 5%. 13/16 with clear resection margins post ESD remain in follow up. Of these 11/13 (87%) remain free of disease at most recent biopsy (median follow up 6 months, range 0–38). Both recurrences were LGD at the resection site. One was treated with laser ablation and the other with repeat ESD. There were no perforations or bleeding seen in our cohort during ESD

**Conclusion** In this small cohort of early gastric neoplasia, ESD appears to provide a safe and effective alternative to surgery with encouraging durability although our follow up time is short. Early recognition of lesions is essential to offer patients a minimally invasive curative intervention. With increasing use of high definition endoscopy more patients will become eligible for therapy. Long term durability remains to be seen.

**Disclosure of Interest** None Declared.

#### PTH-046 ANALYSIS OF METACHRONOUS COLORECTAL ADENOMA SITES SUGGESTS PROXIMAL OCCURRENCE IS MORE PROBABLE

doi:10.1136/gutjnl-2013-304907.533

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**Introduction** A human sporadic colorectal adenoma may influence the formation of another adenoma even after its removal, with up to 60% of such patients developing metachronous adenomas following adenoma excision. However data regarding the occurrence site of a metachronous colorectal adenoma relative to the index adenoma is scarce. Therefore, we investigated whether a metachronous colorectal adenoma was more likely to occur in the same, proximal or distal segment as the index adenoma.

**Methods** A prospectively-maintained database was interrogated to identify all colonoscopies performed over a ten-year period at a single university teaching hospital. All patients undergoing polypectomy were cross-referenced against a histological database to confirm adenoma status. Patients with synchronous adenomas were excluded. The site of adenoma removal at index and subsequent

colonoscopy was recorded and categorised into three groups (proximal, distal or same segment).

**Results** 15,121 colonoscopies and 4759 polyp events were recorded. 361 patients (235 male, 126 female, median age [range] 66 [32–91] years) developed a single metachronous adenoma at follow-up colonoscopy. Metachronous adenomas were more likely to develop in a different bowel segment (61%, 95% c.i. 56% > 66%) to that of the index adenoma (39%, 95% c.i. 34% > 44%;  $P < 0.01$  one way Chi-squared test). Metachronous adenomas were more likely to occur at a site proximal (41%, 95% c.i. 36% > 46%) to the index adenoma than either the same segment (39%, 95% c.i. 34% > 44%) or a more distal segment (20%, 95% c.i. 16% > 24%;  $P < 0.01$  one way Chi-squared test). Proximally-sited metachronous adenomas were more likely to occur in a segment further away (mean [SD] segments travelled 3.5 [2.3]) from the index adenoma than distally-sited metachronous adenomas (2.6 [1.8] segments travelled;  $P < 0.01$  Kruskal-Wallis one way ANOVA).

**Conclusion** A metachronous human sporadic colorectal adenoma is more likely to be found in a section of the colorectum proximal to that of the index adenoma. Travel in segments may be significant. Taken together, the data suggest research effort into underlying mechanisms of metachronous adenoma is needed.

**Disclosure of Interest** None Declared.

#### PTH-047 A PROSPECTIVE STUDY ON THE IMPACT OF A 'BOWEL CLEANSING CARE BUNDLE' ON INPATIENT COLONOSCOPY VISUALISATION SCORES: A LONDON DISTRICT HOSPITAL EXPERIENCE

doi:10.1136/gutjnl-2013-304907.534

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**Introduction** It is recognised that a well prepared colon increases adenoma detection and removal rates<sup>1</sup> and the discovery of other significant pathology at endoscopy. Several factors can lead to a sub-optimal outcome at inpatient colonoscopy but inadequate bowel preparation is a major contributor<sup>2</sup>. Potentially, this leads to repeat and/or alternative procedures and costly and prolonged hospital length of stays. 'Care Bundles' improve outcomes by decreasing the unwanted variation in clinical care and ensure the application of accepted clinical practices<sup>3</sup>. Consequently, we created a *bowel cleansing bundle* to address these issues and see whether it would lead to better visualisation scores.

**Methods** All inpatients requiring colonoscopy were recruited over two six-month periods at a London district hospital. A bowel cleansing bundle was devised formalising accepted clinical guidelines and it was implemented for all subsequent inpatient colonoscopies during the latter study phase. The bundle included sections on timings for the administration of bowel preparation agents, cessation of anti-motility agents, nutrition and hydration. Visualisation scores were noted from the endoscopists' reports (good, moderate and poor) and patients were followed up until discharge.

**Results** In total there were 93 eligible procedures. 53 patients in the pre-bundle population [56% Male, average age 69 years] and 40 patients in the post-bundle population [three exclusions, 57% male, average age 64 years] of which: 'good' visualisation scores = 45% vs 81%, 'moderate' = 21% vs 1% and 'poor' = 34% vs 16%. Implementation of the bundle led to significantly superior 'good' visualisation scores ( $p < 0.001$ ).